

		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031385

Facility Name: SKOKIE MEADOWS N CENTER #1

Address: 9615 N. KNOX AVE. SKOKIE 60076
Number City Zip Code

County: COOK

Telephone Number: (847) 679-4161 Fax # (815) 329-8633

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 03/23/88

Type of Ownership:

☐ VOLUNTARY, NON-PROFIT
☐ Charitable Corp.
☐ Trust

IRS Exemption Code

☒ PROPRIETARY
☐ Individual
☐ Partnership
☐ Corporation
☒ "Sub-S" Corp.
☐ Limited Liability Co.
☐ Trust
☐ Other

☐ GOVERNMENTAL
☐ State
☐ County
☐ Other

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or
Administrator
of Provider

(Signed) _____ (Date) _____
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid
Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) _____ (Date) _____
(Print Name and Title) BOB KAGDA PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1

0031385 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>113</u>	Skilled (SNF)	<u>113</u>	<u>41,245</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>113</u>	TOTALS	<u>113</u>	<u>41,245</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>30,557</u>	<u>3,346</u>	<u>5,024</u>	<u>38,927</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,557</u>	<u>3,346</u>	<u>5,024</u>	<u>38,927</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 94.38%

D. How many bed-hold days during this year were paid by Public Aid?

687 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?

YES

☐

NO

☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES

☐

NO

☒

I. On what date did you start providing long term care at this location?

Date started 03/23/88

J. Was the facility purchased or leased after January 1, 1978?

YES

☒

Date _____

NO

☐

K. Was the facility certified for Medicare during the reporting year?

YES

☒

NO

☐

If YES, enter number

of beds certified

_____ and days of care provided

2,378

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL

☒

MODIFIED

CASH*

☐

CASH*

☐

Is your fiscal year identical to your tax year?

YES

☒

NO

☐

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	161,851	11,359	7,820	181,030		181,030	0	181,030			1
2	Food Purchase		145,211		145,211	(10,494)	134,717	0	134,717			2
3	Housekeeping	117,777	14,108	0	131,885		131,885	0	131,885			3
4	Laundry	55,387	23,920	0	79,307		79,307	0	79,307			4
5	Heat and Other Utilities			87,805	87,805		87,805	197	88,002			5
6	Maintenance	0	15,922	35,824	51,746		51,746	(3,690)	48,056			6
7	Other (specify):*			7,802	7,802		7,802	0	7,802			7
8	TOTAL General Services	335,015	210,520	139,251	684,786	(10,494)	674,292	(3,493)	670,799			8
	B. Health Care and Programs											
9	Medical Director	0		1,200	1,200		1,200	0	1,200			9
10	Nursing and Medical Records	1,523,111	142,683	50,984	1,716,778		1,716,778	0	1,716,778			10
10a	Therapy	47,353		175,914	223,267	(79,555)	143,712	0	143,712			10a
11	Activities	74,149	10,699	941	85,789		85,789	0	85,789			11
12	Social Services	75,165		4,810	79,975		79,975	0	79,975			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			291	291		291	0	291			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	1,719,778	153,382	234,140	2,107,300	(79,555)	2,027,745	0	2,027,745			16
	C. General Administration											
17	Administrative	177,375		546,279	723,654		723,654	(566,066)	157,588			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			87,067	87,067		87,067	744	87,811			19
20	Dues, Fees, Subscriptions & Promotions			83,736	83,736		83,736	(45,474)	38,262			20
21	Clerical & General Office Expenses	46,448	12,212	265,935	324,595		324,595	(164,794)	159,801			21
22	Employee Benefits & Payroll Taxes			354,255	354,255	10,494	364,749	0	364,749			22
23	Inservice Training & Education			4,156	4,156		4,156	40	4,196			23
24	Travel and Seminar			1,435	1,435		1,435	0	1,435			24
25	Other Admin. Staff Transportation			18,234	18,234		18,234	0	18,234			25
26	Insurance-Prop.Liab.Malpractice			77,389	77,389		77,389	0	77,389			26
27	Other (specify):*			0	0		0	16,195	16,195			27
28	TOTAL General Administration	223,823	12,212	1,438,486	1,674,521	10,494	1,685,015	(759,355)	925,660			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,278,616	376,114	1,811,877	4,466,607	(79,555)	4,387,052	(762,848)	3,624,204			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			121,613	121,613		121,613	9,937	131,550			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			600,871	600,871		600,871	(14,651)	586,220			32
33	Real Estate Taxes			181,415	181,415		181,415	0	181,415			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			51,005	51,005		51,005	5,988	56,993			35
36	Other (specify):* amort.mort cost.			88,362	88,362		88,362	0	88,362			36
37	TOTAL Ownership			1,043,266	1,043,266	0	1,043,266	1,274	1,044,540			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0	79,555	79,555	0	79,555			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			61,868	61,868		61,868	0	61,868			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	61,868	61,868	79,555	141,423	0	141,423			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	2,278,616	376,114	2,917,011	5,571,741	0	5,571,741	(761,574)	4,810,167			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	9,937	30		9
10	Interest and Other Investment Income	(10,246)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(4,405)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(4,132)	21		18
19	Entertainment	0	20		19
20	Contributions	(250)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(34,933)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(10,712)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(50,890)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (105,631)		\$ 0	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(655,943)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (655,943)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B))	\$ (761,574)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule therapy	x		79,555	10-a	46
47	TOTAL (C): (sum of lines 38-46)			\$ 79,555		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line	Reference
1	DEFERRED MAINTENANCE	\$ -3690	6	1
2				2
3	Transfer costs to related nursing homes	(47,200)	17	3
4	(skokie 2, momence, sheldon)			4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(50,890)		49

Summary A

12/31/2001

[illegible]

Summary B

Facility Name & ID Number

0031385

Report Period Beginning:

01/01/2001 Ending

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFFE	100%	SKOKIE MEADOWS II	SKOKIE	PREMIER MGMT	SKOKIE	BOOKKEEPING
		MOMENCE MEADOWS	MOMENCE			AND
		SHELDON MEADOWS	SHELDON			MANAGEMENT

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	\$ 546,279			\$	(546,279)	1
2	V	21	OUTSIDE CLERICAL SVC	248,500				(248,500)	2
3	V								3
4	V	5			PREMIER MANAGEMENT		197	197	4
5	V	17			PREMIER MANAGEMENT		27,413	27,413	5
6	V	19			PREMIER MANAGEMENT		744	744	6
7	V	20			PREMIER MANAGEMENT		421	421	7
8	V	21			PREMIER MANAGEMENT		44,880	44,880	8
9	V	27			PREMIER MANAGEMENT		16,195	16,195	9
10	V	23			PREMIER MANAGEMENT		40	40	10
11	V	35			PREMIER MANAGEMENT		5,988	5,988	11
12	V	21			PREMIER MANAGEMENT		42,958	42,958	12
13	V								13
14	Total			\$ 794,779			\$ 138,836	\$ * (655,943)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative	100%	70,826	7	14.00	SALARY	\$ 27,413	17-7	1
2			BANKING								2
3			FINANCE								3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 27,413		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1 # 0031385 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PREMIER MANAGEMENT
Street Address 9933 N. LAWLER
City / State / Zip Code SKOKIE, IL 60077
Phone Number (847) 679-7733
Fax Number (847) 679-7736

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	10,000	5	\$ 900	\$	2,193	\$ 197	1
2	17	OFFICE SALARY	PER RESIDENT DAY	10,000	5	125,000	125,000	2,193	27,413	2
3	19	DATA PROCESSING	PER RESIDENT DAY	10,000	5	3,394		2,193	744	3
4	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	10,000	5	1,919		2,193	421	4
5	21	CLERICAL	PER RESIDENT DAY	10,000	5	204,649	134,850	2,193	44,880	5
6	27	PAYROLL TAXES	PER RESIDENT DAY	10,000	5	73,847		2,193	16,195	6
7	23	SEMINARS	PER RESIDENT DAY	10,000	5	183		2,193	40	7
8	35	OFFICE RENT	PER RESIDENT DAY	10,000	5	27,304		2,193	5,988	8
9	21	CLERICAL	PER RESIDENT DAY	10,000	5	153,972	153,972	2,790	42,958	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 591,168	\$ 413,822		\$ 138,836	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1			X	MORTGAGE	\$45,000.00	04/23/96	\$ 4,750,000	\$	04/20/21	0.0980	\$ 307,527	1	
2	SUCCESS NAT BANK		X	WORKING CAPITAL	INT ONLY						6,357	2	
3	CAMBRIDGE		X	MORTGAGE			6,822,050	6,810,889			182,851	3	
4	REAL ESTATE TAX										1,288	4	
5												5	
	Working Capital												
6	US TRUST		X	WORKING CAPITAL	INT ONLY						9,722	6	
7	SOUTHTRUST		X	WORKING CAPITAL							76,882	7	
8	OLD KENT		X	WORKING CAPITAL							11,839	8	
9	TOTAL Facility Related				\$45,000.00		\$ 11,572,050	\$ 6,810,889				\$ 596,466	9
	B. Non-Facility Related*												
10	TREASURY STOCKS										4,405	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$ 0	\$ 0				\$ 4,405	14
15	TOTALS (line 9+line14)						\$ 11,572,050	\$ 6,810,889				\$ 600,871	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS N CENTER #1 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031385

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	10-10-304-042-0000	NURSING HOME	\$ 176,545.00	\$
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 176,545.00	\$ 0.00

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 32,048 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

		1	2	3	4	
A. Land.		Use	Square Feet	Year Acquired	Cost	
1		NURSING			\$ 347,575	1
2						2
3		TOTALS			\$ 347,575	3

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	113		90		\$ 1,968,925	\$ 62,506		\$ 62,506	\$	\$ 648,518	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENT			1987	4,888	155	20	155		3,372	9
10	IMPROVEMENT			1988	3,196	101	31.5	101		1,388	10
11	IMPROVEMENT			1990	29,530	937	31.5	937		10,359	11
12	IMPROVEMENT			1991	20,962	665	31.5	665		7,012	12
13	IMPROVEMENT			1992	18,635	593	31.5	593		5,587	13
14	IMPROVEMENT			1993	50,200	1,594	31.5	1,594		14,139	14
15	IMPROVEMENT			1993	8,052	206	39	206		1,725	15
16	IMPROVEMENT			1994	71,864	1,843	39	1,843		13,938	16
17	FIRE DAMPERS			1995	4,980	128	39	128		880	17
18	NURSE STATION REMODELING			1995	70,129	1,798	39	1,798		11,613	18
19	CONCRETE WORK, PATIO, RAMPS			1995	21,904	1,460	39	1,460		9,673	19
20	RESIDENT ROOM REMODELING			1996	25,459	653	15	653		3,673	20
21	ROOF			1996	1,200	31	39	31		186	21
22	REHABBING 1ST FLOOR CORRIDOR LOWER WALLS			1997	14,497	372	39	372		1,690	22
23	DOOR			1997	1,455	37	39	37		183	23
24	ELEVATOR RENOVATION			1997	14,791	379	39	379		1,563	24
25	FIRE DAMPERS			1998	7,282	187	39	187		724	25
26	EXHAUST FANS			1998	4,135	106	39	106		387	26
27	FIRE DAMPERS & 21 GRILLS			1998	22,408	575	39	575		2,081	27
28	ACCESS PANELS & FIRE DAMPERS			1998	2,720	70	39	70		219	28
29	TILING			1999	14,344	368	39	368		935	29
30	KIL-BAR			1999	3,587	92	39	92		234	30
31	WALL HEATERS			1999	6,392	164	39	164		417	31
32	DOOR			1999	1,190	30	39	30		77	32
33	WINDOW REPLACEMENT			1999	61,410	1,575	39	1,575		4,003	33
34	SHOWER ROOM TILING			1999	9,206	236	39	236		600	34
35	GENERATOR			2000	62,880	2,287	27.5	2,287		3,430	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	TILLING	2000	\$ 6,052	\$ 220	27.5	\$ 220	\$	\$ 330	37
38	WALL COVERING	2000	33,819	8,282	7	8,282		9,973	38
39	AWNING	2001	2,951	58	27.5	58		58	39
40	CORNICES	2001	1,741	34	27.5	34		34	40
41	ROOF	2001	50,988	1,004	27.5	1,004		1,004	41
42	DOOR	2001	2,160	43	27.5	43		43	42
43	ELEVATOR DOOR	2001	10,450	206	27.5	206		206	43
44	TWO DECK ROOFS	2001	12,100	238	27.5	238		238	44
45	5 TON CONDENSING UNIT	2001	2,854	56	27.5	56		56	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 2,649,336	\$ 89,289		\$ 89,289	\$ 0	\$ 760,548	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$664,607	\$28,561	\$41,320	\$12,759	10 YRS	\$276,116	71
72	Current Year Purchases	18,814	3,763	941	(2,822)	10 YRS	941	72
73	Fully Depreciated Assets	276,047			0		276,047	73
74					0			74
75	TOTALS	\$959,468	\$32,324	\$42,261	\$9,937		\$553,104	75

D. Vehicle Depreciation (See instructions.)*										
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$ 0		\$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			\$ 0	\$ 0	\$ 0	\$ 0		\$ 0	80

E. Summary of Care-Related Assets			1	2	
		Reference	Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,956,379	81	**
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 121,613	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 131,550	83	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 9,937	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,313,652	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)					
	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress			
	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- YES
- NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized
- by the length of the lease
-
-

9. Option to Buy:
- YES
- NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- YES
- NO
16. Rental Amount for movable equipment: \$
- 28,025
- Description:
- SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PASSENGER VAN	1995 FORD SUPER	\$ 600.00	\$ 9,775	17
18	ADMINISTRATOR	1999 CADILLAC ELDORADO	600.00	5,193	18
19			472.00	7,085	19
20			927.00	927	20
21	TOTAL		\$ 2,599.00	\$ 22,980	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$
13.	/2003	\$
14.	/2004	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$		\$	\$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	\$ 0	\$ 0	\$ 0	\$ 0
10	SUM OF line 9, col. 1 and 2 (e)	\$ 0			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

12345678										
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-8	hrs	\$		\$ 26,624	\$		\$ 26,624	1
2	Licensed Speech and Language Development Therapist	39-8	hrs			924			924	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-8	hrs			52,007			52,007	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 79,555	\$		\$ 79,555	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,627,309	\$	1
2	Cash-Patient Deposits	3,094		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,392,636		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,168		6
7	Other Prepaid Expenses	35,352		7
8	Accounts Receivable (owners or related parties)	187,245		8
9	Other(specify):	63,851		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,345,655	\$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	347,575		13
14	Buildings, at Historical Cost	1,968,925		14
15	Leasehold Improvements, at Historical Cost	680,411		15
16	Equipment, at Historical Cost	753,313		16
17	Accumulated Depreciation (book methods)	(1,472,902)		17
18	Deferred Charges	164,258		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(164,258)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	630,542		22
23	Other(specify):	176,557		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,084,421	\$ 0	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,430,076	\$ 0	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 88,192	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	539,966		29
30	Accrued Salaries Payable	96,754		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	176,545		32
33	Accrued Interest Payable	45,531		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 946,988	\$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	35,375		39
40	Mortgage Payable	6,810,889		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 6,846,264	\$ 0	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 7,793,252	\$ 0	46
47	TOTAL EQUITY(page 18, line 24)	\$ (1,363,176)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,430,076	\$ 0	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (907,207)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (907,207)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(455,969)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (455,969)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ 0	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (1,363,176)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 4,958,054	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,958,054	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	146,071	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 146,071	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	10,246	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 10,246	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	NET OF VENDING COMISSIONS	1,401	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 1,401	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,115,772	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	684,786	31
32	Health Care	2,107,300	32
33	General Administration	1,674,521	33
	B. Capital Expense		
34	Ownership	1,043,266	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	61,868	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,571,741	40
41	Income before Income Taxes (line 30 minus line 40)**	(455,969)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (455,969)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	8,083	8,508	\$ 211,416	\$ 24.85	1
2	Assistant Director of Nursing					2
3	Registered Nurses	28,452	31,266	620,630	19.85	3
4	Licensed Practical Nurses	3,443	3,742	65,191	17.42	4
5	Nurse Aides & Orderlies	66,957	70,481	625,874	8.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,172	4,486	47,353	10.56	8
9	Activity Director					9
10	Activity Assistants	8,887	9,257	74,149	8.01	10
11	Social Service Workers	5,939	6,599	75,165	11.39	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,238	17,460	161,851	9.27	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	13,477	14,649	117,777	8.04	18
19	Laundry	7,353	7,992	55,387	6.93	19
20	Administrator	5,436	5,783	177,375	30.67	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,364	3,398	46,448	13.67	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	171,801	183,621	\$ 2,278,616 *	\$ 12.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 7,820	1-3	35
36	Medical Director	O	1,200	9-3	36
37	Medical Records Consultant	N	4,704	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,560	10-3	39
40	Physical Therapy Consultant	L	171,776	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	941	11-3	44
45	Social Service Consultant	E	4,810	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 192,811		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
JOAN WILLEY	ADMIN	0	\$ 79,192	Workers' Compensation Insurance	\$	23,849	IDPH License Fee	\$
REBECCA MAGANA	ADMIN	0	49,114	Unemployment Compensation Insurance		13,791	Advertising: Employee Recruitment	1,286
GEORGENE MOGYOROSSY	AST. ADMIN	0	48,377	FICA Taxes		173,140	Health Care Worker Background Check	25,287
AILEEN ROSENBERG	AST. ADMIN	0	692	Employee Health Insurance		111,322	(Indicate # of checks performed)	
				Employee Meals		10,494	MARKETING/ADV/PROMO	45,645
				Illinois Municipal Retirement Fund (IMRF)*				0
				EMPLOYEE BENEFITS - OTHER		7,269	CONTRIBUTIONS	250
				EMPLOYEE PHYSICAL EXAMS		19,423	DUES & SUBSCRIPTIONS	9,611
				PENSION/PROFIT SHARING PLANS		5,461	LICENSES & PERMITS	1,657
TOTAL (agree to Schedule V, line 17, col. 1)				CHICAGO HEAD TAX		0	DUES & SUBSRIPTIONS-REL PARTY	421
(List each licensed administrator separately.)			\$ 177,375	INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense	(250)
B. Administrative - Other				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising	(34,933)
							Yellow page advertising	(10,712)
Description			Amount				TOTAL (agree to Sch. V, line 20, col. 8)	
PREMIER MANAGEMENT - MANAGEMENT FEES			\$ 546,279	TOTAL (agree to Schedule V, line 22, col.8)	\$	364,749	\$ 38,262	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 546,279	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
(Attach a copy of any management service agreement)				Description	Line #	Amount	Description	Amount
C. Professional Services							Out-of-State Travel	\$
Vendor/Payee	Type		Amount					
			\$					
							In-State Travel	
								1,435
							Seminar Expense	
								0
SEE SCHEDULE ATTACHED			87,067				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 87,067				TOTAL	\$ 1,435

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	2001	\$ 4,429	3	\$	\$	\$	\$ 739	\$ 1,477	\$ 1,477	\$ 736	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 4,429		\$	\$	\$	\$ 739	\$ 1,477	\$ 1,477	\$ 736	\$	\$

Facility Name & ID Number SKOKIE MEADOWS N CENTER #1

0031385

Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL LONG TERM CARE \$5605
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 0 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 61,868
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 10,494 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	7,820
	REPAIRS & MAINTENANCE	0
		0
		7,820
3	HOUSEKEEPING	
		0
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	38,423
	ELECTRICITY	30,396
	WATER	14,311
	CABLE TV - LOBBY	4,675
		0
		87,805
6	MAINTENANCE	
	GROUNDS MAINTENANCE	1,312
	PAINTING & DECORATING	4,429
	BUILDING REPAIRS	1,758
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	11,949
	ELEVATOR MAINTENANCE & REPAIR	2,782
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	2,115
	FIRE SERVICE	2,446
	CONTRACTED BLDG MAINT	9,033
		0
		0
		35,824
7	OTHER	
	SCAVENGER	7,802
	SECURITY SERVICE	0
		7,802
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	1,200
		1,200

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	11,441
	PURCHASED SERVICES	29,779
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTAN XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	4,704
	PHARMACY CONSULTANT XVIII B 39-2	1,560
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	3,500
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		50,984
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	4,138
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	171,776
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		175,914
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	941
		0
		941
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	4,810
		0
		4,810
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

LINE		SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION		
	PATIENT TRANSPORTATION	291	291
17	ADMINISTRATIVE		
	MANAGEMENT FEES	XIX B546,279	546,279
18	DIRECTORS FEES	0	0
19	PROFESSIONAL SERVICES		
	DATA PROCESSING	XIX C5,332	
	ADMINISTRATIVE CONSULTANTS	XIX C0	
	PROFESSIONAL FEES	XIX C81,735	
		0	87,067
20	FEES,SUBSCRIPTIONS,PROMOTIONS		
	ENTERTAINMENT & MARKETING	VI 19 XIX F0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F34,933	
	EMPLOYEE WANT ADS	XIX F1,286	
	CONTRIBUTIONS	VI 20 XIX F250	
	DUES & SUBSCRIPTIONS	XIX F9,611	
	LICENSES & PERMITS	XIX F1,657	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F10,712	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F25,287	83,736
21	CLERICAL & GENERAL OFFICE EXPENSES		
	BANK CHARGES	0	
	EQUIPMENT REPAIR & MAINTENANCE	0	
	OUTSIDE CLERICAL SERVICES	248,500	
	PENALTIES / OVERDRAFT CHARGES	VI 184,132	
	HOME OFFICE EXPENSE	0	
	THEFT & DAMAGE LOSS	0	
	TELEPHONE	13,303	
	MESSENGER SERVICE	0	
		0	265,935

LINE		SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES		
	FICA TAXES	XIX D173,140	
	UNEMPLOYMENT COMPENSATION	XIX D13,791	
	WORKERS COMPENSATION INSURANC	XIX D23,849	
	HOSPITALIZATION INSURANCE	XIX D111,322	
	EMPLOYEE BENEFITS - OTHER	XIX D7,269	
	UNION PENSION PLAN	XIX D19,423	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D0	
	401-K MATCHING	XIX D5,461	
	CHICAGO HEAD TAX	XIX D0	354,255
23	INSERVICE TRAINING & EDUCATION		
	EDUCATION & SEMINARS	4,156	4,156
24	TRAVEL & SEMINARS		
	EDUCATION & SEMINARS	XIX G0	
	TRAVEL	XIX G1,435	
		0	
		0	1,435
25	ADMIN. STAFF TRANSPORTATION		
	TRANSPORTATION - STAFF	18,234	18,234
26	INSURANCE - PROP. LIAB & MALPRACTICE		
	GENERAL INSURANCE	77,389	77,389
27	OTHER		
	BAD DEBTS	VI 240	
		0	0

GRAND TOTAL COLUMN 3 OTHER

1,811,877

SKOKIE MEADOWS N CENTER #1
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	145,211	PATIENT MEALS	116781
LESS SALES TAX	0	ADD EMPLOYEE MEALS	9125
	-----		-----
NET FOOD	145211	TOTAL MEALS/YEAR	125906
TOTAL PATIENT CENSUS	38,927	NET FOOD	145211
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	125906

TOTAL PATIENT MEALS	116781	COST PER MEAL	1.15
		TIME EMPLOYEE MEALS	9125
ADD # EMPLOYEE MEALS/DAY	25		-----
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	10494
	-----		=====
TOTAL EMPLOYEE MEALS	9125		